

## Substance Use History Form

Client Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Which of the following substances have you used, EVEN ONCE?**

| ✓<br>if<br>Used | Substance   | Frequency of Use<br>(# of days per week,<br>month, year, etc.) | Amount per Use<br>(# of drinks/hits/pills,<br>\$ amount, etc.) | When was your<br>last use of this<br>substance? |
|-----------------|---|--|--|---|
|                 | <b>Alcohol</b><br><i>(Beer, Wine, Liquor)</i>   |  |  |   |
|                 | <b>Marijuana</b><br><i>(Cannabis, "Weed," "Pot")</i>  |  |  |   |
|                 | <b>Cocaine</b><br><i>(Including Crack)</i>  |  |  |   |
|                 | <b>Other Stimulants</b><br><i>(Amphetamines, Methamphetamines,<br/>Adderral, Ritalin, etc.)</i>                 |  |  |   |
|                 | <b>Heroin</b>   |  |  |   |
|                 | <b>Other Opiates</b> <i>(Oxycodone,<br/>Hydrocodone, Methadone, Morphine,<br/>Codeine, Buprenorphine, etc.)</i> |  |  |   |
|                 | <b>Depressants/Sedatives</b><br><i>(Benzos, xanax, barbiturates,</i>  |  |  |   |
|                 | <b>Hallucinogens</b><br><i>(PCP, LSD, "Shrooms," Ecstasy,<br/>Ketamine, etc.)</i>                               |  |  |   |
|                 | <b>Inhalants</b><br><i>("Whippets," paint thinner, glue,<br/>volatile solvents, etc.)</i>                       |  |  |   |
|                 | <b>Nicotine/Tobacco</b>   |  |  |   |
|                 | <b>Other:</b>   |  |  |   |

**Have you ever had treatment or "classes" for drug or alcohol abuse or as a result of a DUI or drug related offense?**     Yes     No

*If Yes, Please complete the following:*

| Where?<br>(Name of Facility/Location) | When?<br>(Year/Month/Dates of Attendance) | Did you<br>complete<br>successfully? |
|---------------------------------------|---|--------------------------------------|
| 1.                                    |   |                                      |
| 2.                                    |   |                                      |
| 3.                                    |   |                                      |
| 4.                                    |   |                                      |
| 5.                                    |   |                                      |